MEMORANDUM TO PERSONNEL FILE

This is to certify that I have been advised of the "Panel of Physicians" and its purpose.

I understand that if I am involved in an on-the-job injury and emergency treatment is **NOT** necessary, I must accept the services of a physician from our panel. If I desire to obtain medical service from a physician not listed on our panel, I understand that I will be responsible for the medical expenses and any time away from work will not be covered under the workers' compensation claim.

The physician selected may arrange for appropriate consultations, referrals and other specialized medical services, as the nature of the injury requires. If I am dissatisfied with the physician selected, I may make one change to a second physician also listed. Any further changes require the permission of DOAS/Division of Risk Management Services claims specialist. If the claims specialist and I are unable to reach an agreement, I can contact the State Board of Workers' Compensation for assistance.

In the case of an emergency, I should seek treatment at the nearest emergency room. If additional follow-up care is needed, I must select a physician from the agency's posted panel of physicians.

I understand that I must notify my supervisor immediately following any on-the-job incidents regardless if the incident resulted in an injury. Delays in notification can result in denial of payment for medical services rendered.

If my claim is accepted as compensable and I am receiving weekly indemnity benefits (or it has been no longer than 120 days since I last received indemnity benefits) I understand I am entitled to **ONE** independent medical examination by a physician of my choice. Should I exercise this right, I will notify DOAS/Division of Risk Management Services **in writing in advance** of the examination. The cost will be paid by DOAS/Division of Risk Management Services, but no diagnostic procedures performed since my on-the-job injury and costing in excess of $250.00 will be repeated by my independent physician. If this cost does exceed $250.00, I understand I may be expected to pay for such procedures.

_____	_____	_____
SIGNATURE OF EMPLOYEE	DATE	PERSONNEL OFFICER or EMPLOYEE SUPERVISOR